

PROPOSAL OF POLICY DEVELOPMENT FORM

(1) Policy ID NUMBER (if known): SHORT TITLE:

Effective Date of Policy Being Revised: _____

Title: _____

(2) Initiating Office: Dep Sec- _____ Ofc/Admin- _____ Div/Unit _____

(3) New Policy ☐ Routine Update ☐ Major Revision ☐ Vacate/Repeal ☐

(4) Summary of Major Issues or Changes Proposed: _____

(5) Why are these being initiated?

☐ State Statute ☐ Federal Regulation ☐ Administration Decision

(6) If changes are due to State Statute, indicate Bill Number, Name, Year and Chapter Number of legislation: _____

(7) Date draft will be sent to Policy Administrator: _____

(8) Describe potential impact on other DHMH programs (including Local Health Department's and facilities) and indicate who will be included in the development and review of this policy. _____

(9) List the groups outside of the Department who are interested in this policy and who will be included in the development and review. _____

(10) Contact person's name and phone number:

Name

Phone

(11) APPROVED:

Deputy Secretary or Chief of Staff

Date